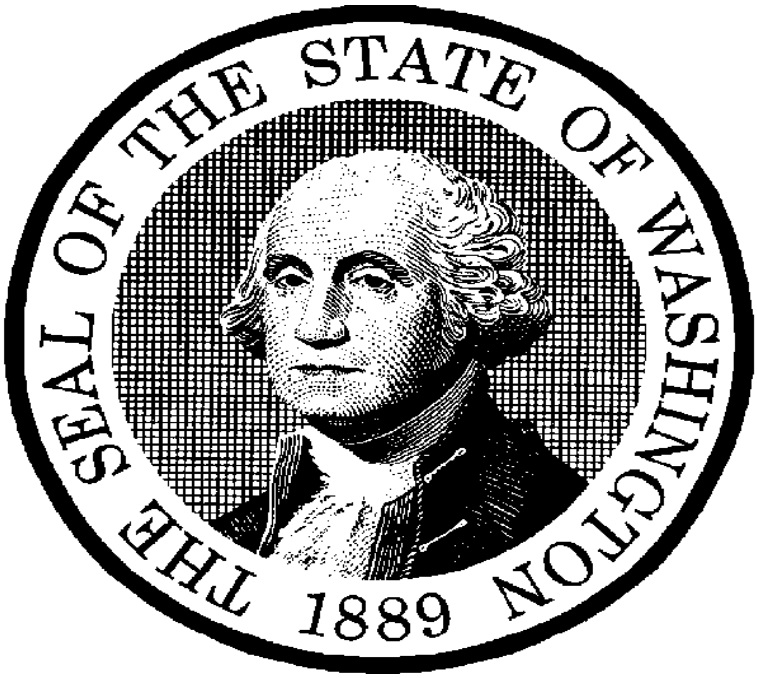
Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration



Occupational Therapy Program

Billing Instructions

(WAC 388-545-0300)

July 1999

Copyright Disclosure

About this publication

This publication supersedes all previous billing instructions for Occupational Therapy Services. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Home Health Services
- School Medical Services
- Neurodevelopmental Centers
- Outpatient Hospital

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 1999

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

Applying for a provider

Call:
(800) 562-6188 and
Select Option #1

or call one of the following numbers:

(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

This is a blank page…

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Client - An applicant for, or recipient of, DSHS medical care programs.

Department - The state Department of Social and Health Services (DSHS). (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Health Care Financing Administration Claim Form (HCFA-1500) - A claim form used to bill for Medicaid services.

Health Maintenance Organization (HMO) – An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis. (WAC 388-500-0005)

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.

(WAC 388-538-001)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS use to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, `course of treatment' may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Primary Care Case Manager (PCCM) – A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly, management fee.

Program Support, Division of (DPS) -The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

Provider, or Provider of Service - An institution, agency, or person:

(a) Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and

(b) Eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number - A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with the Medical Assistance Administration.

Remittance and Status Report - A report produced by the claims processing system in the MAA Division of Program Support that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Occupational Therapy

Who is eligible to provide occupational therapy?
[WAC 388-545-0300(1)]

The following providers are eligible to enroll with MAA to provide occupational therapy services:

- A licensed occupational therapist;
- A licensed occupational therapy assistant supervised by a licensed occupational therapist; or
- An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

Referral and Documentation Process

Adults (Age 21 and older) [WAC 388-545-0300 (3)(f)]

A provider must prescribe the occupational therapy services. The therapy must:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Be part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger)

The Healthy Kids/EPSDT screening provider must:

- Determine if there is a medical need for occupational therapy; and
- Document the medical need and the referral in the child's occupational therapy file.

The occupational therapist must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring Healthy Kids/EPSDT screening provider for information concerning the need for occupational therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the child(ren) the provider has referred to them for services.

Client Eligibility

Who is eligible? [WAC 388-545-0300 (2)]

Clients presenting MAID cards with the following identifiers are eligible for services under the Occupational Therapy Program:

- **CNP** (Categorically Needy Program)
- **Children's Health**
- **GA-U No Out of State Care** (General Assistance-Unemployable)
- **Detox** (Alcoholism and Drug Addiction Treatment and Support Act)
- **LCP-MNP** (Limited Casualty Program-Medically Needy Program)
  - ✓ Only clients 20 years of age or younger; or
  - ✓ Clients receiving home health care services only
- **Emergency Hospital And Ambulance Only** (Medically Indigent Program)
  - ✓ Hospital Setting Only

Who is not eligible?

Clients presenting MAID cards with the following identifiers are not eligible for services under the Occupational Therapy Program:

- **Family Planning Only** (Limited Coverage)
- **QMB Medicare Only**

Are clients enrolled in managed care eligible?

YES! Clients with an identifier in the HMO column on their MAID card are enrolled in one of MAA's Healthy Options managed care plans and must receive all occupational therapy services directly through their Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number located on their MAID card. If clients have a PCCM (Primary Care Case Manager) indicator on their MAID card, they must get a referral from their PCCM to receive occupational therapy services.

Coverage

MAA pays only for covered occupational therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary, as determined by a health professional; and
- Begun within 30 days of the date prescribed.

What is covered? [WAC 388-545-0300 (5)(6)]

Unlimited occupational therapy program visits for clients 20 years of age and younger.

MAA covers the following services per client, per calendar year:

- One (1) occupational therapy evaluation;
- Two (2) durable medical equipment (DME) needs assessments; and
- Twelve (12) occupational therapy program visits.
- Twenty-four (24) additional occupational therapy program visits (see next page).

One application of Transcutaneous Neurostimulator (TENS) per client, per lifetime.

Additional Coverage (Client 21 years of age and older) [WAC 388-545-0300(5)(e)]

MAA will cover a maximum of 24 occupational therapy program visits in addition to the original 12 visits only when billed with one of the following:

- **Principle** diagnosis codes:

Diagnosis Codes	Condition
315.3-315.9, 317-319	Medically necessary conditions for developmentally delayed clients
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
749-749.25	Severe oral/motor problems that interfere with adequate nutrition (infants) and cleft palate and cleft lip
758.0	Down's syndrome
781.2-781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800-829.1	Surgeries involving extremities-Fractures
851-854.1	Intracranial injuries
880-887.7	Surgeries involving extremities-Open wounds with tendon involvement
941-949.5	Burns
950-957.9, 959-959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Physical Medicine & Rehabilitation (PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

854	Traumatic Brain Injury (TBI)
952.8-952.9	Spinal Cord Injury, (Paraplegia & Quadriplegia)
900.82, 344.0, 344.1	
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss, for Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 - 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive Severe Burns
707.0 & 344.0	Skin Flaps for Sacral Decubitus for Quads only
897.6-897.7, 887.6-887.7	Bilateral Limb Loss

Visit Limitations

If time is included in the CPT code description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

The following are considered occupational therapy program visits and are part of the 12-visit limitation:

- Therapeutic exercises (CPT code 97110);
- Neuromuscular reduction (CPT code 97112);
- Aquatic therapy with therapeutic exercises (CPT code 97113);
- Prosthetic training (CPT code 97520);
- Therapeutic activities (CPT code 97530);
- Self-care/home management training (CPT code 97535); and,
- Community/work reintegration training (CPT code 97537).

☞ **Note:** Two 15-minute increments, in any combination (same or different) of the above codes, will be counted as one occupational therapy visit.

- Cognitive Skills (CPT codes 97532 and 97533).

☞ **Note:** Each 15-minute increment of cognitive skills will be counted as one occupational therapy program visit.

The following are not included in the 12-visit limitation:

- Evaluation of occupational therapy (CPT code 97003). Allowed once per calendar year, per client.
- Checkout for orthotic/prosthetic use (CPT code 97703). Two 15-minute increments are allowed per day. Procedure code 97703 can be billed alone or with other occupational therapy allowed CPT codes.
- DME needs assessments (CPT code 97703). Two allowed per calendar year. Two 15-minute increments are allowed per assessment.
- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). Two 15-minute increments are allowed per day. Procedure code 97504 can be billed alone or with other occupational therapy CPT codes.
- ~~Custom splints (cockup and/or dynamic) (State unique procedure code 0002M).~~

Duplicate services for Occupational, Physical, and Speech Therapy are not allowed for the same client when both providers are performing the same or similar intervention(s).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need occupational therapy in addition to that which is allowed by diagnosis, the provider must request MAA approval to exceed the limits.

Limitation extensions (LE) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all eligibility groups receive all services. For example: therapies are not covered under the medically indigent (MI) program.

Limitation Extensions

Limitation Extensions are cases where a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instruction and Washington Administrative Code (WAC). Providers must use the EPA process to create their own EPA numbers. These EPA numbers will be subject to post payment review.

In cases where the EPA criteria cannot be met and the provider still feels that additional services are medically necessary, the provider must request MAA approval for limitation extension. The request must state the following in writing:

1. The name and Patient Identification Code (PIC) of the client;
2. The therapist's name, provider number, and fax number;
3. The prescription for therapy;
4. The number of visits used during that calendar year;
5. The number of additional visits needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and CPT code; and
10. The place of service.

Send your request to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must create a **9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing multiple EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form exactly as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA or PA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: The 9-digit authorization number for additional occupational therapy visits for a client who has used 12 OT visits this calendar year and subsequently has had knee surgery would be **870000644** (**870000** = first six digits of all expedited prior authorization numbers, **644** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must maintain documentation in the client's file to support how the expedited criteria were met, and have this information available to MAA on request.

Washington State
Expedited Prior Authorization Criteria Coding List
For Occupational Therapy (OT) LEs

OCCUPATIONAL THERAPY
CPT: 97110, 97112, 97113, 97520, 97530, 97532, 97533, 97535, 97537

Code	Criteria
644	**An additional 12 Occupational Therapy** visits when the client has already used the allowed visits for the current year and has **one** of the following: 1. Hand\Upper Extremity Joint Surgery 2. CVA not requiring acute inpatient rehabilitation
645	**An additional 24 Occupational Therapy** visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.

Are school medical services covered?

MAA covers occupational therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? [WAC 388-545-0300 (7)]

MAA does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Fee Schedule

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT™ code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Brief Description	July 1, 2004 Maximum Allowable	
		Non Facility Setting	Facility Setting
64550	Apply neurostimulator	$11.11	$5.44
97003	OT evaluation	48.06	37.41
97110	Therapeutic exercises	17.46	17.46
97112	Neuromuscular reeducation	17.46	17.46
97113	Aquatic therapy with therapeutic exercises	19.95	19.95
97504	Orthotic training	18.59	18.59
97520	Prosthetic training	17.00	17.00
97530	Therapeutic activities	17.68	17.68
97532	Cognitive skills development	14.96	14.96
97533	Sensory integration	15.64	15.64
97535	Self care mngment training	18.14	18.14
97537	Community/work reintegration	16.55	16.55
97703	Prosthetic checkout	15.42	15.42

Billing

What is the time limit for billing?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days after you provide a service(s).

- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible on the date of service:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.

- **MAA will not pay if:**

  - ✓ The service or product is not covered by MAA;
  - ✓ The service or product is not medically necessary;
  - ✓ The client has third party coverage, and the third party pays as much as, or more than MAA allows for the service or product; or
  - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person is found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill MAA for those services.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Assistance IDentification (MAID) card. An insurance carrier's billing time limit for claim submissions may vary. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for clients who are eligible for both Medicare and Medicaid?

Some Medicaid clients are also eligible for Medicare benefits. When you have a client who is eligible for both Medicaid *and* Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier, *first*. Medicare is the primary payor of claims.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. MAA will pay up to Medicare's Allowable or MAA's allowable, whichever is less.

An X in the *Medicare* area on the client's MAID card (area 9) indicates Medicare enrollment.

QMB (Qualified Medicare Beneficiaries Program Limitations):

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

- If the client has a CNP or MNP MAID card in addition to the QMB MAID card, and the service you provide is covered by Medicare *and* Medicaid, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- MAA will also reimburse for services that are *not* covered by Medicare but *are* covered under the CNP or MNP program.

QMB-MEDICARE Only (Qualified Medicare Beneficiaries)

The reimbursement criteria for this program is as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- If only Medicare and **not** Medicaid covers the service, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- If Medicare does **not** cover or denies the service, MAA will not reimburse for it.

What records does MAA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service must be in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor(s) and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying Clients of Their Rights (Advanced Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM, Medicare, Indian Health, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

17. **Name of Referring Physician or Other Source**: Required. Enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

The referring provider's Medical Assistance provider number or name and the statement "Healthy Kids/EPSDT referral" must be entered in the appropriate field.

19. **Reserved for local use:** Enter "T" for school contracted services noted in the client's IEP or IFSP. **If you have more than one EPA number to bill, place both numbers here.**

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. These are the only appropriate codes for this program:

Code Number	To Be Used For
22	Outpatient Hospital
11	Office
12	Home
99	Other

24C. **Type of Service**: No longer required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCs) procedure code for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

Group: Enter the group number assigned by MAA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): N-120346BOBO A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BOBO NATALIE

3. PATIENT'S BIRTH DATE MM DD YY: 12 03 46 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 500 CENTRAL

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 555-1199

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR BROWN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	01	03	10	01	03	11		97003		343.9	4800	1				
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 4800

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 4800

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

OCCUPATIONAL THERAPY USA
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7000001

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	**Please Enter:**
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach Medicaid?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. These are the only appropriate codes for this program:

Code Number	To Be Used For
22	Outpatient Hospital
11	Office
12	Home
99	Other

24C. **Type of Service**: No longer required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCs) procedure code for the services being billed. **Coinsurance and Deductible**: Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days Or Units**: Required. Enter the appropriate number of units.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Enter the occupational therapy clinic or individual number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

SAMPLE A: MEDICARE COINSURANCE AND SUPPLEMENTAL INSURANCE

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): H-041915HANSON

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HANSON HARRY

3. PATIENT'S BIRTH DATE MM 04 DD 19 YY 15 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 16 STUMP ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123 456 789

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA - SUPPLEMENT

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☒ NO ☐ *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	03	10	01	03	11		97003	11.50	343.9	4800	1				40.80
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 4800

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 4800

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/16/03
$13.01

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

OCCUPATIONAL THERAPY USA
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

SAMPLE B: MEDICARE DEDUCTIBLE AND COINSURANCE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): R-111231BROWNB

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BROWN ROBERT

3. PATIENT'S BIRTH DATE MM DD YY: 11 12 31 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 23 MAINE

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	01	03	10	01	03	11		97504	5.50	343.9	3458	2				27.46
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 3458

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 3458

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/16/03
$13.01

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

OCCUPATIONAL THERAPY USA
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7654321

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

This is a blank page…